BUBER BEHIND BARS*

E. T. Barker, M.D.[1] and M. H. Mason[2]

Introduction

This paper will attempt to describe some aspects of an intensive treatment program presently operating in an institution for mentally ill persons. The patients there are confined by law, against their will, until they change. Most of them stand to be confined for long periods of time; most of them do not feel themselves to be mentally ill; most of them do not agree that they need treatment.

The Setting:

The Ontario Hospital Penetanguishene is one of twenty-three similar institutions maintained in the Province by the Department of Health. It is distinguished from the rest chiefly by the presence of Oak Ridge, an administratively integrated but structurally separate division of the hospital. A maximum security building of eight 38-bed wards, it looks like and is built like a prison. Each ward has individual rooms ranging down both sides of a long corridor which debouches into a euphemistic sunroom capable of seating all ward members. Each room, with its bed, sink and toilet, is completely open to the corridor through the bars that form its front wall and door. There is no privacy.

Patients are referred to the Oak Ridge Division in roughly equal proportions from three sources: the courts, reformatories and penitentiary, and other Ontario Hospitals. From the courts come those found not guilty by reason of insanity, those found unfit to stand trial, and those remanded for thirty and sixty-day periods of observation. Reformatories and other Ontario Hospitals send those with whom their own facilities of treatment and security are insufficient to cope. Patients at Oak Ridge therefore vary widely in their legal classifications, some being seriously involved with the law, some not at all. Almost all were sent, and are being held, against their will.

In September 1965 it was decided to develop one of the Oak Ridge wards into an Intensive Treatment Unit, with the hope that the methods evolved there might eventually be used on some other wards as well. Our object was not so much to realize any preconceived psychiatric theory, as to mould a flexible and experimental approach around a few very basic assumptions.

The Major Assumptions:

1) *Sickness as the failure of communication*

The first, and perhaps most basic assumption underlying our program, was that sickness was essentially an inability to communicate. It consisted of the ways in which the patient was unable to relate either with himself or with others. We saw genuine communication as an end in itself, and each patient as one in some way unable to enter into dialogue with others. The fundamental parameters of illness as inability to communicate were thought to be well illustrated by Buber, when he speaks of

> ". . . monologue disguised as dialogue, in which two or more men, meeting in space, speak each with himself in strangely tortuous and circuitous ways, and yet imagine that they have escaped the torment of being thrown back on their own resources . . . . A debate in which the thoughts are not expressed in the way in which they existed in the mind, but in the speaking are so pointed that they may strike home in the sharpest way, and moreover without the men that are being spoken to being regarded in any way present as persons; a conversation,

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[1]Assistant Superintendent, Ontario Hospital, Penetanguishene.
[2]Patient — Intensive Treatment Unit, Ontario Hospital, Penetanguishene.

characterized by the need neither to communicate something, nor to learn something, nor to influence someone, nor to come into connection with someone, but solely by the desire to have one's own self-reliance confirmed by marking the impression that is made, or if it has become unsteady, to have it strengthened; a **friendly chat**, in which each regards himself as absolute and legitimate, and the other as illegitimate and questionable; a **lovers' talk**, in which both partners alike enjoy their own glorious soul and their precious experience — what an underworld of faceless spectres of dialogue!". (3).

Of course, in equating illness with an inability to communicate, a criterion was established by which the entire population of Canada was moderately crazy. Nor did we wish to imply that there was little wrong with Oak Ridge patients. Far from that, these men had in many cases been certified mentally ill because they were exceedingly dangerous. There were a dozen killers on the ward where it was planned to develop the program. However, it seemed to be evident that phenomenologically illness resulted in a breaking down of communication, or was such a breakdown; and that therapy would involve re-establishing or strengthening the dialogue between the patient and others.

2) *Dialogue as Therapy*

We felt with Laing (11) that psychotherapy

"consists in the paring away of all that stands between us, the props, masks, roles, lies, defences, anxieties, projections and introjections, in short, all the carry-overs from the past, transference and counter-transference, that we use by habit and collusion, wittingly or unwittingly, as our currency for relationships. It is this currency, these very media, that re-create and intensify the conditions of alienation that originally occasioned them."

Perhaps psychotherapy is nothing but "an obstinate attempt of two people to recover the wholeness of being human through the relationship between them" (11). This is the primary experience, and it seemed to us that once this was achieved, the symptoms surrounding the self would wither away, useless. In Buber's terms,

"Each of us is encased in an armour, which we soon . . . no longer notice. There are moments which penetrate it, and stir the soul to sensibility. And when such a moment has imposed itself upon us, and we then take notice, and ask ourselves, 'Has anything in particular taken place? Was it not of the kind that I meet every day?', then we may reply to ourselves, 'Nothing in particular, indeed it is like this every day, only we are not there every day'" (3).

We felt that what might generally appear to be an idealistic approach to illness was realistic in a setting where patients were confined for very long periods of time. The time, and if administrative measures were taken, the space and opportunity, existed for patients to open themselves to the genuine dialogue that lies around them *in potentia* every day.

The terms of such a dialogue are, to paraphrase Seeley (13), a number of complex simplicities: simplicities of relation, focus, value, process and product. The relation is one which joins the parties to it in perhaps the greatest intimacy combined with the greatest distance that is in the compass of human experience. One patient must stand close enough to another to be his friend, far enough away to see what is happening. The focus is upon making what is unconscious, conscious. This is a two-way street, a process of mutual education. What each patient discovers of himself to his companion is part of his contribution; what he discovers of his companion to his companion is the other half. The paramount and only necessary joining value on both sides is the pursuit of truth, and the process is the continuous examination of the world as it is mirrored and distorted in the self, and the self as it is projected and distorted in the world. As Seeley concludes, "The product is, at a minimum, two people who know more about each other, each about the world, and each about himself. That is all. Perhaps, it is enough."

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3) *The patient as agent of therapy*

The third assumption was that as far as possible professional staff would not be used in the program, but rather that the patients themselves would be the principal agents of therapy. As long as there are large numbers of patients and small numbers of professed experts, it is futile to develop any new techniques which are to depend heavily on staff for their success. Further, a program of treatment based on patients rather than staff lends itself to employment in other than hospital settings: reformatories, penitentiaries, training schools, or, in a modified form, in schools and universities, where one can never get 'enough' staff and where the inmates and students possess all that is necessary to create and sustain their program, provided that the correct administrative moves are made.

More importantly, another reason concerned the involvement of the professional in treatment. While it is true that psychiatrists, psychologists and social workers devote many years to accumulating a great deal of information about, and experience in the treatment of the mentally ill patient, there is some doubt about the efficacy of this training in making them therapists. It may sometimes increase the distance between them and their patients. It may sometimes be unaccompanied by the great indefinables of therapy: congruence, empathy, openness, the ability to encounter, call them what you will.

The obstacles to communication are doubled when, in settings such as Oak Ridge, the psychiatrist is in direct control of the liberty of the patient. It is unfortunate but true that this control of the patient's liberty is more or less sick, as the psychiatrist himself is more or less sick. Professionals do not often enough seriously maintain the habit of considering the ways in which their own sicknesses are barriers to the treatment of their patients. This is particularly true of those working in institutions which provide roles of power and security, for the role system seems to guarantee that few of them will think of themselves as 'equal to' the patient in any other than a diffuse philosophical-humanistic sense. The more ill-trained or inexperienced or maladjusted he is, the more will his role magnify those defects. The more he is in direct authority, or is seen to be, the more of a problem his sickness becomes (5).

Quite apart from the foregoing, however, it would appear that the patient is in many ways better equipped than the professional for a direct, helpful encounter. For one thing, he lives with his 'patient' for 24 hours a day, works, eats and enjoys recreation with him. For another, he is immediate to his 'patient', has no power over him, and is much closer to his mode of experience than any professional. And finally, he is 'committed' to a parallel experience in a way that no professional therapist can ever be. It is for him, in a real sense, a way of life, and he has no status or role to lose in the encounter. True, he is sick; true, he may be disturbed, disoriented, or immature. But he is human and unmagical.

What perhaps may reassure those unaccustomed to thinking in these terms is the fact that the short-comings of patient therapists tend to be ruled out in groups, where pathologies cancel and reciprocate one another. To give a very crude example, a schizophrenic will object to the slick solution to a problem adeptly flashed out by a psychopath. The psychopath will point with some justice to the woolliness and diffuse idealism of the schizophrenic. Or again, no one can so unerringly highlight the subtle manipulations of a severely sick psychopath as one who is similarly crazy. No one can perceive the first crumblings of a schizophrenic disintegration more quickly than one who has once similarly collapsed himself.

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In short then, it was a major assumption in the development of our community that genuine encounter between patients could be therapeutic, and the role of the professional was cast as an ancillary one: to use his administrative power to set up the space for such encounters, and mould their terms towards dialogue.

4) *Total experience*

Another major assumption in structuring the program was that as many hours of the day should be used as was possible. The Oak Ridge patient is confined against his will because of certain aspects of his behaviour which are seen by society to warrant detaining him until he changes them. This lays some obligation on the hospital staff to help the patient to change the patterns of thinking and behaviour that prevent his release, and to do so as quickly as possible.

If it is desired to change behaviour, then, to take an extreme example, it is a gross waste of the patient's time to provide him with a milieu that reinforces illness for 23 hours of the day, and then attempt in perhaps one hour of the day some sort of experience aimed at reversing the process. Ideally, the patient should be allowed no experience that does not in some way contribute to his getting well, and every minute of his stay ought to be designed intentionally to bring about recovery and release. Even though the best means to this goal may not be known, maximal use should be made of those techniques currently thought to be helpful.

There is some question about how far a person who is not a patient can commit himself to a treatment of this sort. It is perhaps unrealistic to expect those cast in 'sane' roles to attempt to involve themselves at all in a total-experience, 24-hour form of therapy. Perhaps they cannot live in 'the world' and 'the treatment community' at the same time. Many factors seem involved. For one thing, it is hard for staff on an eight-hour shift to 'know' what is going on, the way permanent members do. Again, there often arises a barrier between those who can leave and those who must stay. 'Well adjusted' staff have little motivation to participate equally and fully in an anxiety-provoking situation, likely to produce change. Another factor is the fact that many staff have very immediate pressures on them from family or community or professional obligations — pressures that are very close and real but beyond the patients' sphere of involvement. There are accounts in the literature (8) of communities which ran into great difficulty because of the pressures placed on staff members who attempted what may be an impossible 'double life'. Perhaps they should either enter the treatment program as a fully participating member, or stay out of it and practice administrative therapy, leaving to others the business of direct encounter.

5) *Coercion and the goad to freedom*

To make the statement that patients should not be allowed any unhelpful experience is of course to stumble into the thorny question of coercion and non-acceptance. Those who feel, with Carl Rogers (12), that even to evaluate is to corrupt the helping relationship, might object to suggestions that to use force — is to make such a relationship possible; that to repeatedly and without compromise thrust a person's illness before his eyes — is to sustain such a relationship; that to insist upon a person's examining his own behaviour — is to make him free. Approaches of that sort seem to run counter to many of psychiatry's most cherished notions.

To what extent is force legitimate in treating patients who are incarcerated because of illnesses that they do not recognize, or for which they wish to receive no treatment? We think that when one is confronted with such persons, one must first decide if such imprisonment is warranted and if it is not, the task is

to 'treat' society rather than the patient. But in situations where patients are quite properly being held against their will until they change, it seems humane and helpful to use force, at least to the point of increasing their range of choice, of increasing their awareness of themselves, and others, to the point where, as far as can be determined, what they do, they self-consciously choose to do. The validity of force depends on this assumption. If the process were one of eradicating a set of disapproved ideas and washing in different social values, then we would be committing offences as grievous as those involved in setting up the Third Reich – indeed, the more sinister, because of their subtlety. On the other hand, if our patients did not choose to deviate from society's norms, but rather were driven to such deviations by internal unresolved conflicts, then we should help them to resolve such conflicts by every means at our disposal, including force, humiliation, and deprivation, if necessary. Physical force brought the patient to our hospital, physical force maintains him there, and this force will not be lifted until he changes his behaviour in a recognizable way.

In our opinion, there is no question that the treatment necessary to produce some remission of the illnesses suffered by most Oak Ridge patients would be impossible on a voluntary basis.

True, it seems evident that in the traditional, autocratic hospital, the use of force is antitherapeutic in most cases (5, 14). However, it may be that the effect of force depends upon the motivation for its use, the way in which the motivation is conveyed from the agent to the patient, and the way in which it is perceived by the patient. If communication is maximized, coercion may be therapeutic, particularly when it is exerted by peers rather than authority figures. Our feeling was that force could most usefully be employed in treatment, particularly the treatment of the asocial and antisocial personality disorders; and that as communication approaches a maximum, the permissible use of force also approaches a maximum.

The Ward and The Program

The development of the program since September 1965 is of considerable interest, and merits separate treatment. It was rapid, turbulent, and frequently dangerous. In this paper, we will only attempt to describe the situation as it was for a period from November 1966 to February 1967. The ward structure and program arrangements remain flexible: that is, the number and composition of committees, programmed hours and types of programming, all fluctuate and change from month to month as the Unit evolves.

As has been said, the ward accommodates 38 patients. In February 1967 half of them were between 20 and 25, and the distribution of I.Q. scores approximated the normal curve. Legally, 13 had been charged with murder or manslaughter, nine with theft, five with assault or rape, and the remainder spread evenly through categories of arson, incest, indecent assault, extortion, and so on. Fourteen were diagnosed 'schizophrenics', a dozen 'pathological personality' or 'immature personality', and the remainder were borderline defectives and other classifications. Educationally, there was an even distribution between grades III and XII, with a few above and below. The vast majority of patients came from social classes 5 and 6.

Although there had been a number of transfers on and off the ward, twenty-two of the patients had experienced at least a year of the developing program by February 1967. All were involved in a minimum of 80 hours of structured interaction each week, all phases of which were compulsory. A variety of group interactions occurred which placed the patient in a number of different settings, with a number of different expectations.

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Roles in work settings occupied about a third of the patient's day. All patients were employed either in industrial therapy or school. This work was compulsory, and with the exception of school, the emphasis was solely upon learning the basic requirements of the work situation: how to receive instructions and carry them out, how to make decisions, how to co-operate with others, and how the patient's pathology interferes with these things. No attempt was made at any 'vocational' training, since it seemed foolish to teach specialized skills to a man who did not know the basic skill of working.

All patients were members of one or another of the committees which managed the ward. Although modifications are made to the committee structure month by month, a fairly stable schema had emerged by February 1967. The major committees of seven patients each, Steering, Welfare, Medication, and Small Groups/crisis, were concerned respectively with program planning and organization, participation and sanctions, the management of all patient medication, and the arrangement and monitoring of all small groups (*ad hoc* therapy groups), together with the immediate handling of any crisis. Jointly, these committees initiated, sustained and planned the entire treatment program. A Planning Board met once each week to assess the last week, and plan the time-table for the coming week. A Policy Group, consisting of four patients, one professional staff member and one attendant staff member acted as the chief administrative unit for the ward, formulating all major policy and having the power of veto over the recommendations of all other committees. An Assessment Committee kept complete treatment files for each patient, showing medication, small groups treatment, sanctions, details of visits and mail and so on.

Twice a day, seven days a week, the entire community assembled for community meetings of 1¼ hours each. The first of these served as a feedback centre for work groups and committees: the preceding 24 hours were reviewed, committee decisions relayed and discussed. The second was concerned with the discussion of small group activities, focusing upon the problems of individual patients.

For an hour and a quarter each day on six days a week the entire ward subdivided into small groups which were assembled on the basis of individual patient needs. When a ward member was 'shook-up', as the patients say, that is, depressed or hostile, threatening to act out, etc., the Small Groups Committee formed a group of from four to eight patients who were considered the most suitable group for him to talk to under the particular circumstances of the crisis, selecting from among people who were involved, people who had experienced similar situations, his current friends or enemies. Small groups were also assembled to make periodic reviews of a patient's progress, to examine his motivation for a particular act, or to make specific recommendations that a committee did not have the time to consider at sufficient length.

For an hour each day, seven days a week, the ward subdivided into fixed dyads, and, for a further hour, fixed triads. That is, each patient was locked in a room with one (dyad) or two (triad) other patients. No patient was allowed to write, read, or sleep. He was expected to talk, or to listen. These dyads and triads remained constant: that is, the same groups of two and three people met for an hour in a locked room each day for as long as they were in the hospital. This sort of grouping was based on the assumption that in any close relationship a person will encounter obstacles to communication from which he may unhealthily choose to withdraw. If, however, he is forced to stay with the person or persons involved in the situation for an hour a day, indefinitely, he

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is forced to solve the problem, usually by identifying those aspects of himself and the other person which created the difficulty.

The status of dyads and triads was discussed in dyad and triad groups of six patients which subsequently fed back into dyad and triad ward meetings. Much of the most meaningful interactions took place in these groupings of two and three people, where the evolution of a relationship was made much more apparent to the partners by its forced continuity.

The patients often remarked that the unit was in the business of upsetting people, and that was true as far as it went. The process of anxiety-arousal, recognition and change was a central one, and was assisted by two major tools.

Video-tape: a closed-circuit TV/video-tape recording system was in use, providing a powerful resource for the objective observation of group dynamics. Small groups, dyads, triads, and ward meetings could be observed 'live' without intrusion, or recorded and played back for analysis. The use of a zoom lens enabled a sophisticated operator to concentrate on many events that would have been lost to the most alert participants.

Demystifying drugs: From March 1966 to February 1967 a gradually increasing number of drugs were used to help uncover unconscious feelings in patients who were willing to undergo such an experience. All were. A complex system of safeguards became elaborated around their use. The need for such a system is evident where 30 mg. of methedrine and 1/75 gr. of scopolamine are injected twice a day for four days. Sodium amytal, scopolamine, methedrine, imipramine†, and dexedrine, were all used either singly or in combination to reduce defences. Concomitantly, efforts were made to reduce the use of tranquillizers to an absolutely necessary minimum. We employed the term 'demystifying drugs' to express something of the purpose in using them, adapting a term coined by R. D. Laing (10).

From November, 1966 to February 1967 three to five patients at a time were undergoing continuous courses of treatment with these drugs. Prior to that time, they were administered in single doses only, with gaps of weeks or months between doses. In the latter phases the drugs were administered daily for periods of up to two weeks. During the period of reaction, which might extend for a month after the last treatment, patients continued to participate in the program, and were observed for 24 hours daily by their fellow patients. In the daytime a disturbed patient was secured by a locked canvas wrist strap to a series of patients in four-hour shifts set up by the Small Groups Committee. Again, tactical use was made of the disturbed patient's friends and enemies, for being handcuffed to another for long periods forces an inescapable interaction. At night, he was placed in an 'Intensive Care Unit' (ICU), accommodating up to nine disturbed patients who could be observed all night by six better-integrated peers. Two 'screened rooms' formed a part of this ICU, and were used both for sleeping, and for the daytime protection of very seriously disturbed patients. (A 'screened room' is a colloquialism for a standard Oak Ridge maximum security room with a barred front, which has been stripped of all furnishings and fitted out with a metal screen to prevent the breaking of windows.)

In January the ward appeared to be capable of treating up to five patients at a time with the 'demystifiers'. The use of combinations of scopolamine and methedrine proved particularly useful in reducing the defences of the psychopath, while dextro-amphetamine/imipramine†† appears to promise well for schizophre-

†Tofranil.

††Dexamyl/Tofranil. (Dexamyl is a combination of dextro-amphetamine plus amytal.)

nics. There was some apparent success with an almost ritual employment of sodium amytal. The use of LSD-25 began in February 1967.

Schematically, then, the program consisted of confrontation, anxiety-arousal, analysis, and support in committees, dyads, triads, and small groups, supported by community meetings, the use of demystifying drugs, and the feedback resources of video-tape equipment. There were several ancillary phases of evaluation and recreation. Roughly four hours a week were devoted to physical exercise: 5BX, floor games, soccer, football, volleyball, etc. Ward members were able to watch TV for four hours a week, if they wished. Regularly, a patient was conferenced by the Unit; his chart was read by the Unit psychiatrist, and a current assessment with treatment recommendations was made by a patient group selected by the Small Groups Committee, and usually consisting of his dyad partner, closest friend, enemy, and so on. It is an interesting fact that no patient has yet been considered fit for complete discharge by his peers. Progress reports were completed by a patient committee for each patient, and were included in the hospital file.

For most of the day, then, the patient was exposed to a twofold confrontation, with himself and with others. His role alternated rapidly between worker, committee member, helper, and patient. In some settings, he was treated. In some, he was the treator. Often, he might occupy both roles simultaneously. This sort of alternation was at once an integrative and a disintegrative experience. The individual was forced to pull himself together, sanely, to help someone else. Often, in the process, his own insanity was exposed and pointed out by another, and he was forced to look at that also. For example, a patient while genuinely helping another might be using this as a defence against considering his own difficulties. Predictably on this ward messianism covers a multitude of sins!

But the time and the safeguards existed on the unit for each person to be as honest as he could be. In most settings, it would be considered a heinous crime to tell a suicidal patient that as far as one is concerned, he can go and hang himself. On the Intensive Treatment Unit there were always enough resources of genuine caring to allow for the full expression and examination of not-caring; what is more, not-caring is a part of reality with which the mentally ill person must learn to come to terms. Experience taught us that in a group of 38 patients, no one was ever without compassion from at least one other.

The Two Poles and The Field

The schematic program is one thing, but its description tends to obscure what is felt to be of value. Fundamentally, we saw it only as a means of setting up the space for dialogue, not as the dialogue itself.

In this space, an intensity of exchange was generated (7) from which a number of interesting phenomena arose. One of these was the creative tension that seemed to exist between certain diagnostic categories. The patients on the ward tend to speak frequently of schizophrenics and psychopaths — labels which convey to them not so much the illnesses psychiatrists refer to, as a common way of regarding two sorts of people, the way in which these people see themselves and others, and the way in which they act upon themselves and others.

The inability of the schizophrenic to describe the way he feels, and the further inability of the psychopath to draw on analogous emotional experience, have created a situation in many ways poignant for both personality types. It is perhaps a significant phenomenon that friendships on the ward tend to be formed across diagnostic boundaries rather than within them. The psychopath may feel himself to be confronted with someone, most of whose feelings and expressions tend to appear meaningless on some

levels. This meaninglessness, however, serves sometimes to underline his own inadequacies and needs. On the other hand, the schizophrenic meets a person who does not respond in kind, but who appears to be possessed of a particular type of self-mastery that accentuates the schizophrenic's own isolation. From this polarity arises a friendship often bristling with threats, but probably founded on the fascination for the foreign, the complementary. While it may seem unlikely that any *rapprochement* could take place on such a basis, we found it not only to be possible, but also most productive.

The mixture of diagnostic types on the ward was a major practical advantage as well, for the polarity referred to seemed to be a major impetus towards change. Intelligent psychopaths displayed great ability in observing details of behaviour, correctly describing it, proposing practical alternatives, and organizing activities. The schizophrenics offered much in terms of emotional support and empathy. For the individual, psychopath or schizophrenic, this combination provided a multi-dimensional picture of his situation, and a wide range of resources with which to fulfil his needs. The program seemed to be stabilized by this combination, which provides checks and balances, softening the raw practicality of the psychopath with the dreaminess of the schizophrenic, schizoid idealism with sociopathic politics.

Permissiveness

The myth of permissiveness often clouds the therapeutic community with its connotations of laxity, and it is worthwhile indicating that in many ways, helpful ways, the Oak Ridge Intensive Treatment Unit is considerably less permissive than a penitentiary. The influence of patient committees was exerted on all the daily activities of the patient. Where he went and what he did, from seven in the morning until ten at night, seven days a week, was determined by his fellow patients in a committee. The small group treatment he received, the medication he took, the penalties of his deviance were all fixed by the appropriate patient groups. He might be called upon by a committee to observe through the night in the Intensive Care Unit, be handcuffed to a dangerous patient, assist in carrying a man bodily to treatment, search a man for razor blades, or a room for broken glass. He might be deprived of his room, his clothes, his mattress, his coffee, or his tobacco, by a committee. As a last resort, he might be stripped by them, and locked in a screened room.

This is far from the sort of permissiveness commonly objected to, and more importantly it is at an extreme remove from the gangsterism of a reform institution inmate subculture. While a bald report of the activities of a patient committee may suggest the weekend pastimes of Storm Troopers, our explanation would be that a seeming rape is attempted in order to impregnate the patient with ideas that may prevent a further, more subtle, and more menacing rape: the rape that the illness perpetrates upon the patient, and the rape that a sick society maintains upon a few of its sicker members. If anything is being brainwashed into or forced upon Oak Ridge patients, it is, we think, the concept of an open system of evaluating, comparing, and questioning, rather than a closed system of revealed truths. It seems to be true, paradoxically, that in some forms of serious mental illness, force must be exerted to move the patient to a position where he can exercise free will, learn to evaluate and choose.

The Indefinite Hospital Sentence

To reach any dialogue to a degree assisting a man's discharge is not easy of course, and if our patients were to be together for only ninety days, then we would say that they might never attain it in a therapeutic form. But many of our patients were charged with serious offences before they were brought to Oak Ridge, and since the law demands

that before they are released there be more than a reasonable assurance that they will not burn, rape, kill or steal again, their stay in Oak Ridge is usually a long one, most often measured in years, and this makes the goal seem more attainable.

The 'indefinite sentence' is felt to be a most crucial factor in producing the anxiety to motivate change. Coupled with Buber, the possibility of a lifetime sentence is seen to offer greater chances of freedom than the iron subcultural brainwashing of a three year bit in penitentiary, where the squares and the rounders seem locked in a relationship of mutual strangulation. The possibility of five years spent in one meaningful stay in hospital seems more attractive than the prospect of twenty years worth of repeated sentences to a limbo of manipulations and sterile violence that progressively dwarf, harden, and anaesthetize the spirit.

Re-training for the World

It must be remembered that a man who has accustomed himself to speak with complete honesty about what he feels and thinks about himself and other people is regarded as something of a nut in our society, and will either make others very uncomfortable or be made so in turn by them. Although we have as yet had no practical experience in releasing a patient from our intensive treatment unit, we hypothesize at the moment that some period of readjustment will be necessary prior to discharge. During this time the patient will re-learn the social rituals and games that his stay in an intensive treatment unit has atrophied. In the summer of 1966, for example, two undergraduate students lived in the unit as 'patient participants' for two months. This was at a time when the program had not reached its full intensity, but even so the students were profoundly affected by their experience (6). One recorded that shortly after his release he was "impatient with superficial talk of any kind", and some time afterwards commented retrospectively that when he left he felt as if he was departing from a sane world populated by partly insane people, to go to an insane world populated by partly sane ones. While we do not feel that we are unfitting our patients for an alienated marketing culture, we do consider that it will take them a short time to adjust themselves to it. Laing's comments (11) on the craziness of contemporary society are most relevant in this context.

The Future

The impact of the community upon most patients has been considerable. With the exception of a few schizophrenics or defectives, definite changes seem to have taken place in all ward members. It is too early to judge whether these changes will be lasting, whether they are the prelude to integration, or whether they are simply the immediate product of the loss of privacy and the intense anxiety upon the ward.

Is exposure to a total experience of this sort helpful? We feel at the moment that two years of this intensive treatment may be of benefit to many patients, especially the young delinquents, not yet emotionally and socially ossified by one of our 'reform' institutions. But only an objective study will provide us with more than convictions about the nature of what is happening. To this end our task is to design and implement a research project that will evaluate the efficacy of this form of treatment. Such plans are under way now, so that what seems subjectively to be having an important effect on patients can be established as valuable or not on a rational basis.

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"In human society, at all its levels, persons confirm one another, in a practical way, to some extent or other, in their personal qualities and capacities, and a society may be termed human in the measure to which its members confirm one another.

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"The basis of man's life with man is twofold, and it is one: the wish of every man to be confirmed as what he is, even as what he can become, by men; and the innate capacity in man to confirm his fellow men in this way. That this capacity lies so immeasurably fallow constitutes the real weakness and questionableness of the human race; actual humanity only exists where this capacity unfolds. On the other hand, of course, an empty claim for confirmation, without devotion for being and becoming, again and again mars the truth of the life between man and man.

"Men need, and it is granted to them, to confirm one another in their individual need by means of genuine meetings: but beyond this they need, and it is granted to them, to see the truth, which the soul gains by its struggle, light up to the others, the brothers, in a different way, and even so be confirmed" (2).

Summary

This paper describes the structure and conceptual foundations of an intensive treatment program operated at the Ontario Hospital, Penetanguishene, a 304-bed maximum security institution which receives patients from the courts, reform institutions, and other mental hospitals.

The philosophy of treatment includes the following assumptions:

1) Mental illness is fundamentally a breakdown in the communication between persons.
2) For a sick person, the most helpful experiences are acts of genuine communication — direct encounters — as defined by Martin Buber, in which each turns to the other in his present and particular being, and addresses him without pretence.
3) The patient is the principal agent of therapy. He is equipped to help his peers better in some ways than the professional whose role is seen as an administratively supportive one creating the space in which direct encounter can occur.
4) Every event in a total institution should enhance the treatment goals.
5) The use of force is legitimate in treating patients for illnesses which they do not recognize, in settings where they will be incarcerated until they change.

An outline of the eighty-hour per week compulsory program describes the variety of group interactions, planned and sustained by patient committees with minimal staff supervision. The establishment of fixed pairings for an hour a day, seven days a week indefinitely as a device of confrontation; the use of video tape equipment as a device of observation; the intensive use of hyoscine hydrobromide, methamphetamine hydrochloride, imipramine hydrochloride, dextroamphetamine sulfate, amobarbital sodium, lysergic acid diethylamide as 'demystifiers' are sketched. Experiences in the simultaneous treatment of schizophrenic and psychopathic personality types are examined, and the need for the objective evaluation of results is affirmed.

The value of this program is felt to be primarily for those settings where patients are held for long periods of time.

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Résumé

L'auteur dépeint la structure et les fondements conceptuels d'un programme de traitement intensif mis en oeuvre à l'Hôpital ontarien de Penetanguishene, établissement à sécurité maximum de 304 lits, qui reçoit des malades envoyés par les tribunaux, les maisons de réforme et d'autres hôpitaux psychiatriques.

Les principes qui président au traitement se fondent sur les suppositions qui suivent:

1) La maladie mentale est en principe une rupture des communications entre les gens.
2) Pour une personne malade, ce qu'il y a de plus utile ce sont les actes de communication véritable – les rencontres directes – telles que les a définies Martin Buber, au cours desquelles chaque malade s'adresse à un autre, dans son état actuel et particulier, sans aucune simulation.
3) Le malade est le principal thérapeute; dans certains cas, il est mieux en mesure d'aider ses pairs que ne pourraient le faire des professionnels dont le rôle se voit comme un appui administratif créant l'ambiance où peuvent se produire les rencontres directes.
4) Chaque événement dans un établissement complet devrait renforcer les objectifs du traitement.
5) Le recours à la compulsion se justifie lorsqu'il s'agit de traiter des malades qui ne se rendent pas compte de leur état, dans des situations où ils seront incarcérés jusqu'à ce que leur attitude se modifie.

Un aperçu du programme obligatoire de 80 heures par semaine dépeint la gamme des interactions collectives, élaborées et maintenues par des comités de malades, avec le minimum de surveillance de la part du personnel. La création de groupes fixes de deux malades pour une heure par jour, sept jours par semaine et cela durant une période indéfinie de temps comme moyen de confrontation; l'emploi de magnétoscopes comme moyens d'observation; l'usage intensif de médicaments tels que le bromhydrate d'hyoscine, le chlorhydrate de métamphétamine, le chlorhydrate d'imipramine, le sulfate de dextroamphétamine, l'amobarbital sodique, le diéthylamide de l'acide lysergique, comme "démystificateurs", tout cela est brièvement décrit. L'auteur examine ce qui est arrivé lorsqu'on a employé simultanément le traitement des malades à personnalité schizophrénique et à personnalité psychopathique, et il soutient qu'on doit faire une appréciation objective des résultats.

On estime que ce programme est utile dans ces situations surtout où les malades sont détenus durant de longues périodes de temps.

I never saw a man who looked
With such a wistful eye
Upon that little tent of blue
Which prisoners call the sky

The Ballad of Reading Gaol

Oscar Wilde
1856-1900